The Edge of Palliative Care: Certainty, But at What Price?

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Introduction

As the law stands in Queensland, and indeed in every other State and Territory in Australia, administering medical treatment that causes or even hastens death is unlawful unless otherwise excused.[2] Treatment that does so exposes those involved in its administration to possible prosecution for murder[3] or manslaughter.[4] This raises practical difficulties for doctors and other health care professionals who administer palliative care in the course of their practice. Effective palliative care may require sufficiently high doses of drugs such that they can hasten the arrival of a patient's death.[5] This raises concerns that health care professionals may be conservative in their palliative treatment, understandably fearful that the doses needed to manage patients' pain can expose them to potential criminal liability.[6]

In response to these concerns, the Member for Nicklin, Mr Peter Wellington MP introduced into the Queensland Parliament a private member's bill called the *Care of the Terminally-Ill Patients Bill 2002* (Qld). After discussions with the Government, Mr Wellington then withdrew the bill and introduced in its place another bill which later became, with the support of the Government, the

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[2] Section 291 of the *Criminal Code 1899* (Qld) makes killing unlawful unless it is otherwise justified or excused and this is clearly wide enough to include where death is caused by medical treatment. "Killing" is defined widely in s293 as causing the death of another whether directly or indirectly, and by whatever means. Of particular interest in the context of palliative care is s296, which provides that hastening a person's death, when that person is labouring under some disorder or disease from another cause, is deemed to be a killing.

[3] Criminal Code 1899 (Qld), s302.

[4] Criminal Code 1899 (Qld), s303.

[5] Although note the contrary view, described as the "morphine causation fallacy", that proper and effective palliative care does not need to hasten a patient's death: M Ashby, 'Of Life and Death: The Canadian and Australian Senates on Palliative Care and Euthanasia' (1997) 5 *Journal of Law and Medicine* 40 at 45. See also M Ashby, 'Hard Cases, Causation and Care of the Dying' (1995) 3 *Journal of Law and Medicine* 152; D Mendelson, 'Quill, Glucksberg and Palliative Care: Does Alleviation of Pain Necessarily Hasten Death' (1997) 5 *Journal of Law and Medicine* 110; EG Brownstein, 'Pain Relief and Causation of Death in the Context of Palliative Care' (2001) 8 *Journal of Law and Medicine* 433.

[6] D Mendelson, 'Quill, Glucksberg and Palliative Care: Does Alleviation of Pain Necessarily Hasten Death' (1997) 5 *Journal of Law and Medicine* 110 at 111 (footnote 13), who cites a number of studies indicating that up to 40 per cent of dying patients receive inadequate pain relief because of these concerns about hastening death.

Criminal Code (Palliative Care) Amendment Act 2003 (Qld).[7] The Explanatory Notes to this amendment identify its goal:

> "… to clarify the obligations of doctors treating terminally-ill patients and to ensure that doctors, including those that follow their orders, who administer palliative care to such patients for the purpose of relieving pain and suffering, are not held under threat of prosecution because an incidental effect of the treatment is to shorten the life of the patient."[8]

Now, since June 2003, health care professionals administering appropriate palliative care in Queensland are protected by section 282A which the Act inserted into the *Criminal Code 1899* (Qld).[9] Queensland is only the second State in Australia to enact such a defence. South Australia was the first jurisdiction to act and included this protection in its *Consent to Medical Treatment and Palliative Care Act 1995* (SA) which is also discussed below.

Section 282A creates an excuse for those who administer palliative care in accordance with its requirements, of which three are most important. The first is that the health care professional must provide the treatment with the intention of relieving pain, and not with the intention of causing the patient's death. This part of the excuse simply enacts the common law doctrine of double effect, an ethical and now legal doctrine that is discussed further below. The second substantive requirement of the excuse is that the treatment provided must be reasonable in the context of good medical practice. This is significant in that it goes beyond the common law doctrine of double effect, and in doing so, creates a new legal obligation on health care professionals. The final major requirement, which also goes beyond the doctrine of double effect, is that the care must be provided by a doctor or confirmed in writing by a doctor. Although section 282A provides greater certainty for those administering palliative care, these additional requirements mean that this certainty comes at a price.

The Doctrine of "Double Effect"

The long title of the *Criminal Code (Palliative Care) Amendment Act 2003* (Qld) states that the Act is "to provide a statutory enactment of the 'double effect' principle for palliative care." Also commonly called the doctrine of "double effect", its application in this context means that it is lawful to administer palliative care even though it may hasten death because the doctor's primary intention is to relieve pain and not to cause death. The key to this doctrine is the doctor's intent. The distinction between treatment that is legal and that which is illegal lies in whether the intent was to ease the pain

[7] The reason cited for this was that the Government had concerns about the drafting of the first Bill: Hansard, Queensland Parliament, 12 March 2003.
[8] Explanatory Notes, Criminal Code (Palliative Care) Amendment Bill 2003 (Qld), p1.
[9] It is noted that s282A provides protection to 'a person', rather than a health care professional. Although the role of others who administer palliative care outside of the health care profession (particularly in a home care setting) is acknowledged, the focus of this article is on the legal obligations of health care professionals.

and suffering of the patient or to cause their death.[10] This doctrine was accepted as part of the common law in England in *R v Adams (Bodkin)*[11] and has been endorsed in a number of English cases since then.[12]

The practical operation of this doctrine is well illustrated by an English case, *R v Cox*,[13] involving one of the very few convictions of doctors for causing death through medical treatment.[14] Cox was the treating doctor of a patient named Boyes who was in agonising pain from rheumatoid arthritis, was near death and had asked for doctors to end her life. Having been unsuccessful in alleviating her pain, Cox administered a dose of potassium chloride and soon after she died. Cox was tried for attempted murder because the prosecution was unable to prove whether it was the potassium chloride or her illness that actually caused the patient's death. In directing the jury, Ognall J employed the doctrine of double effect, making it clear that Cox could only be found guilty if his primary intention was to cause death, rather than relieve pain and suffering. Cox was found guilty of attempted murder. Presumably the jury was convinced his primary intention was to cause death and was therefore unlawful because the medical evidence disclosed that potassium chloride in this context had no curative or analgesic properties and the dose given was twice what was judged to be lethal.[15]

In Australia, the common law remains unclear, as there have been no cases that have decided whether the doctrine of double effect forms part of the law in this country. It is certainly likely that the doctrine would be considered to represent the common law in Australia, and the Explanatory Notes to the amending Act assume that this is the case.[16] This distinction has also been

[10] As to the difficulties in clinical practice associated with this conceptual distinction, see for example, C Douglas et al, 'The Intention to Hasten Death: a Survey of Attitudes and Practices of Surgeons in Australia' (2001) 175 *Medical Journal of Australia* 511 and R Hunt, 'Intention, the Law, and Clinical Decision-Making in Terminal Care' (2001) 175 *Medical Journal of Australia* 516.

[11] [1957] Crim LR 365.

[12] For example, *Airedale National Health Service Trust v Bland* [1993] 1 All ER 821 at 868. It also has widespread approval outside of the courts including being endorsed by the Catholic Church, which is traditionally regarded as "pro-life" and "anti-euthanasia": L Skene, *Law and Medical Practice: Rights, Duties, Claims and Defences*, Butterworths, 1998, pp219-220. See also Queensland Parliamentary Library, *The Care of Terminally-Ill Patients Bill 2002* (Qld): Clarifying the Right of Medical Practitioners to Administer Treatment (Research Brief No 2002/29).

[13] *R v Cox* (1992) 12 BMLR 38.

[14] To the authors' knowledge, there has not been a successful prosecution in Australia of a doctor for having an intention to cause death in the context of palliative care.

[15] Cox was given a suspended sentence and, although admonished by the General Medical Council, was not barred from practising. For a further discussion of this case, see A Grubb, 'Commentary [on the case of Dr Cox]' (1993) 1 *Medical Law Review* 232.

[16] The Explanatory Notes state that the "purpose is not to bring about a change in the law but to clearly reflect the common law that already governs the conduct of those that administer palliative care": Explanatory Notes, *Criminal Code (Palliative Care) Amendment Bill 2003* (Qld), p2. See also Skene who assumes that it is law and cites others who agree: L Skene, *Law and Medical Practice: Rights, Duties, Claims and Defences*, Butterworths, 1998, p220.

accepted by the medical profession and informs clinical decision making in the palliative care field.[17]

However, there is at least some residual doubt raised by academic commentators[18] and this uncertainty is also evidenced by the perceived need for this recent amendment to the law. Further, whether or not the doctrine of double effect would be recognised in Queensland is complicated by s296 of the *Criminal Code 1899* (Qld). It provides that hastening a person's death, when that person is labouring under some disorder or disease from another cause, is deemed to be a "killing". This seems to raise the possibility that bringing on death earlier than that which might occur without palliative care, even if only for the purpose of pain relief, may still attract criminal responsibility.

In light of this legal uncertainty, it is reasonable for health care professionals to be apprehensive when administering the large doses of palliative care drugs that may be needed to relieve pain. Although prosecutions in this field of medical practice are extremely unlikely, the potential repercussions for the individual who is accused of a criminal offence are significant.

In response to these and other concerns, South Australia enacted the *Consent to Medical Treatment and Palliative Care Act 1995* (SA). Amongst other things, this Act legislatively enshrines the doctrine of double effect and provides some protection for doctors in the palliative care field. The relevant parts of section 17 are as follows:

> *(0) A medical practitioner responsible for the treatment or care of a patient in the terminal phase of a terminal illness, or a person participating in the treatment or care of the patient under the medical practitioner's supervision, incurs no civil or criminal liability by administering medical treatment with the intention of relieving pain or distress—*
>
> *( ) with the consent of the patient or the patient's representative; and*
>
> *( ) in good faith and without negligence; and*
>
> *( ) in accordance with proper professional standards of palliative care,*
>
> *even though an incidental effect of the treatment is to hasten the death of the patient.*
>
> *(3) For the purposes of the law of the State—*

[17] The Australian Medical Association voted in May 2002 to support doctors who administer palliative care in accordance with the doctrine of double effect: J Kerin and D Nason, 'Euthanasia Stand Eases', *The Australian*, 27 May 2002, 5. See also medical literature which accepts the doctrine, for example, C Douglas et al, 'The Intention to Hasten Death: a Survey of Attitudes and Practices of Surgeons in Australia' (2001) 175 *Medical Journal of Australia* 511 and R Hunt 'Intention, the Law, and Clinical Decision-Making in Terminal Care' (2001) 175 *Medical Journal of Australia* 516.

[18] For example, P MacFarlane and S Reid, *Queensland Health Law Handbook*, Queensland Department of Health, 2003, p158.

( ) the administration of medical treatment for the relief of pain or distress in accordance with subsection (1) does not constitute an intervening cause of death.

More recently, as already discussed, Queensland has followed suit with its *Criminal Code (Palliative Care) Amendment Act 2003* (Qld). The protection is contained in section 282A:

(0) A person is not criminally responsible for providing palliative care to another person if—

( ) the person provides the palliative care in good faith and with reasonable care and skill; and

( ) the provision of the palliative care is reasonable, having regard to the other person's state at the time and all the circumstances of the case; and

( ) the person is a doctor or, if the person is not a doctor, the palliative care is ordered by a doctor who confirms the order in writing.

(0) Subsection (1) applies even if an incidental effect of providing the palliative care is to hasten the other person's death.

(0) However, nothing in this section authorises, justifies or excuses—

( ) an act done or omission made with intent to kill another person; or

( ) aiding another person to kill himself or herself.

(0) To remove any doubt, it is declared that the provision of the palliative care is reasonable only if it is reasonable in the context of good medical practice.

(0) In this section—

"good medical practice" means good medical practice for the medical profession in Australia having regard to—

( ) the recognised medical standards, practices and procedures of the medical profession in Australia; and

( ) the recognised ethical standards of the medical profession in Australia.

"palliative care" means care, whether by doing an act or making an omission, directed at maintaining or improving the comfort of a person who is, or would otherwise be, subject to pain and suffering.

Section 282A – an Overview

Section 282A of the *Criminal Code 1899* (Qld) operates to create an excuse for the crime of unlawful killing, and indeed for all criminal offences, while providing palliative care. Because it involves criminal law, the onus falls on the Crown to prove beyond reasonable doubt that the health care professional acted outside the protection of the excuse. To successfully do this and secure a prosecution, the Crown would have to exclude at least one of the legal elements of the section beyond reasonable doubt.

The first element of the excuse is that it applies only to the provision of palliative care.[19] This is defined as meaning "care, whether by doing an act or making an omission, directed at maintaining or improving the comfort of a person who is, or would otherwise be, subject to pain and suffering."[20] One important implication of this is that it enshrines the first limb of the doctrine of double effect, because for care to fall within the definition, it must be administered to relieve pain and suffering. Although drafted in different terms, section 17(1) of the South Australian Act contains an equivalent protection. The provision refers to "treatment or care of a patient in the terminal phase of a terminal illness".[21] Further, the medical treatment must be administered "with the intention of relieving pain or distress".[22]

The second element of s282A is that the palliative care must be provided both in good faith and with reasonable care and skill.[23] In the equivalent South Australian provision, the medical treatment must be administered "in good faith and without negligence".[24] It is difficult to know what additional legal effect these words in s282A have as it is argued below that these requirements are already achieved more effectively elsewhere in the section.[25]

The third element of s282A is that it must be reasonable to provide palliative care, having regard to the patient's state at the time and all of the circumstances of the case.[26] What will be "reasonable" is later defined as being only if it is reasonable in the context of "good medical practice".[27] The term "good medical practice" is then defined as meaning good medical practice for the medical profession in Australia having regard to its recognised medical standards, practices and procedures and also the profession's

[19] *Criminal Code 1899* (Qld), s282A(1).
[20] *Criminal Code 1899* (Qld), s282A(5).
[21] The terms "terminal phase" and "terminal illness" are defined in *Consent to Medical Treatment and Palliative Care Act 1995* (SA), s4.
[22] The term "medical treatment" is also defined in *Consent to Medical Treatment and Palliative Care Act 1995* (SA), s4.
[23] *Criminal Code 1899* (Qld), s282A(1)(a).
[24] Consent to Medical Treatment and Palliative Care Act 1995 (SA), s17(1)(b).
[25] This phrase was probably included to maintain consistency with the surrounding provisions of the Code. For example, these words are also found in the preceding section (s282), which creates an excuse in relation to surgical operations.
[26] *Criminal Code 1899* (Qld), s282A(1)(b).
[27] *Criminal Code 1899* (Qld), s282A(4).

recognised ethical standards.[28] The Explanatory Notes make it clear that this definition prevents one doctor from asserting their own subjective view that the particular palliative care administered was reasonable.[29] The South Australian provision has a similar requirement in that protection is afforded only if the medical treatment is "in accordance with proper professional standards of palliative care".[30]

The fourth and final element of the excuse is a procedural one. The palliative care must be provided by a doctor, or at least the order for it must be confirmed in writing by the doctor.[31] Although only a procedural requirement from a legal perspective, this may have significant practical consequences for those, other than doctors, who provide palliative care. In South Australia, there is no requirement of writing as the protection is afforded to a medical practitioner responsible for the treatment or care, or "a person participating in the treatment or care … under the medical practitioner's supervision".[32]

Having stated the elements of this excuse, s282A goes on to enshrine the second limb of the doctrine of double effect by stating that the excuse will still apply even if an incidental effect of providing the palliative care is to hasten the patient's death.[33] However, it does not go further than that as the section also makes a clear and firm statement that euthanasia remains unlawful. The excuse is quite narrow and does not permit an act or omission to be done with the intent to kill the patient.[34] Nor does it justify aiding another person to kill himself or herself.[35]

A Closer Examination

Section 282A is a short section and seeks only to change a very small part of the law. However, it also raises some difficult issues that warrant closer examination.

Defining "Palliative Care"

The section defines palliative care as meaning "care, whether by doing an act or making an omission, directed at maintaining or improving the comfort of a person who is, or would otherwise be, subject to pain and suffering."[36] This is an exhaustive definition and so excludes the meaning given to the term in other contexts, for example, how the term is interpreted in other legal situations,[37] or how the term is defined by the medical profession.[38]

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[28] *Criminal Code 1899* (Qld), s282A(5).
[29] Explanatory Notes, Criminal Code (Palliative Care) Amendment Bill 2003 (Qld), p3.
[30] Consent to Medical Treatment and Palliative Care Act 1995 (SA), s17(1)(c).
[31] *Criminal Code 1899* (Qld), s282A(1)(c).
[32] Consent to Medical Treatment and Palliative Care Act 1995 (SA), s17(1).
[33] *Criminal Code 1899* (Qld), s282A(2). Similar working is used in the concluding words of *Consent to Medical Treatment and Palliative Care Act 1995* (SA), s17(1).
[34] *Criminal Code 1899* (Qld), s282A(3)(a).
[35] *Criminal Code 1899* (Qld), s282A(3)(b).
[36] *Criminal Code 1899* (Qld), s282A(5).
[37] A recent case, *Gardner; re BWV* [2003] VSC 173, about a related but different issue (whether a person wishing to remove a tube that provided the patient with nutrition, hydration

Accordingly, whether a particular treatment regime is considered to be palliative care for the purposes of this section (and therefore possibly attract the defence) will simply depend on whether it falls within the words of that definition.

In a similar vein, the protection provided by the South Australian provision is limited to "treatment or care of a patient in the terminal phase of a terminal illness".[39] "Terminal phase" and "terminal illness" are defined in the legislation.[40] Again, protection is given only if the treatment falls within the statutory definitions.

Intention to Relieve Pain

The crux of the common law doctrine of double effect is intent. If the health care professional's intention is to relieve pain rather than end the patient's life, then his or her action is lawful. Section 282A does not refer expressly to "intent". However, the concept continues to be relevant primarily because of how the term "palliative care" is defined. To fall within the excuse, the care must be "**directed** at maintaining or improving the comfort of a person who is … subject to pain and suffering" (emphasis added). Whether the care was so directed will depend upon that health care professional's intention. The South Australian provision is more explicit as it refers to intention expressly. To obtain protection, the medical treatment must be administered "with the intention of relieving pain or distress".[41]

Section 282A (and its South Australian equivalent) also refers to the health care professional's intention in that it requires that the palliative care administered must be provided in "good faith". The meaning of this requirement is not entirely clear, and no assistance can be gleaned from the Explanatory Notes or the second reading speech. However, it is likely that a health care professional will only be acting in good faith if his or her intention is to relieve pain, rather than cause death. In light of how clearly palliative care is defined, it is suggested that this additional requirement for good faith is unnecessary. It is difficult to envisage a situation where care that is not provided in good faith could still be regarded as being directed at relieving pain as the definition of palliative care demands.

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and medication could be appointed as her guardian) turned on whether this type of treatment was "medical treatment" or "palliative care". On the facts of the case, the Victorian Supreme Court held that the treatment was medical treatment and outside the parameters of palliative care.

[38] For example, Palliative Care Australia defines palliative care as "a concept of care that provides coordinated nursing, medical and allied services for people who are facing a life-limiting illness. This care is delivered, where possible, in the environment of that person's choice. This care provides physical, psychological, social, emotional and spiritual support for patients and families and their friends. The scope of palliative care services includes grief and bereavement support for the patient and family and other carers during the life of the patient and after the patient's death": Palliative Care Australia 'Position Statement: Deliberate Ending of Life (Euthanasia)', 11 September 2001 (copy with authors).

[39] Consent to Medical Treatment and Palliative Care Act 1995 (SA), s17(1).

[40] Consent to Medical Treatment and Palliative Care Act 1995 (SA), s4.

[41] Consent to Medical Treatment and Palliative Care Act 1995 (SA), s17(1).

The critical role that intention plays in the doctrine of double effect means that the same treatment can be administered with two different intentions, one of which will attract prosecution and the other will not.[42] Because the difference between a legal and illegal act is intention, it is very difficult for the Crown to exclude this excuse by proving the appropriate intent. In the absence of a confession or admission made by a health care professional, or perhaps the use of a non palliative drug such as in *Cox's* case, it is highly unlikely that an intent to kill could be established beyond reasonable doubt.[43] In those jurisdictions where this area of law is regulated solely by the doctrine of double effect, this difficulty poses an almost insurmountable hurdle to prosecution. However, in Queensland, s282A also makes "good medical practice" an essential element of the excuse and this may provide a somewhat easier route to prosecution.

"Reasonable" Palliative Care and "Good Medical Practice"

In addition to the requirement of the relevant intent, s282A also limits protection to where the palliative care provided is reasonable. As has already been discussed, for such care to meet this criterion, it must be reasonable in the context of "good medical practice". In South Australia, the requirement is that the medical treatment be administered "in accordance with proper professional standards of palliative care".[44] This is an important element of the excuse as it effectively creates a limit on how far this protection can extend. This raises some interesting issues. The first is how this "good medical practice" will be established. The Act defines the term as meaning good medical practice for the medical profession in Australia having regard to its recognised medical standards, practices and procedures and also its recognised ethical standards.[45]

It appears that the medical profession has not officially endorsed a national set of clinical practice guidelines that specifically address palliative care treatment. However, there are other publications that could be regarded as strong evidence of good medical practice at a national level.[46] More locally based guidelines, such as those produced by a particular hospital or indeed even by Queensland Health, would also be useful although they cannot determine what is good medical practice. The Act specifies, and the Explanatory Notes emphasise,[47] that the term is defined by reference to the

[42] For a medical perspective on this seemingly incongruous approach, see C Douglas et al, 'The Intention to Hasten Death: a Survey of Attitudes and Practices of Surgeons in Australia' (2001) 175 *Medical Journal of Australia* 511 and R Hunt 'Intention, the Law, and Clinical Decision-Making in Terminal Care' (2001) 175 *Medical Journal of Australia* 516.
[43] L Skene, Law and Medical Practice: Rights, Duties, Claims and Defences, Butterworths, 1998, p238.
[44] Consent to Medical Treatment and Palliative Care Act 1995 (SA), s17(1)(c).
[45] *Criminal Code 1899* (Qld), s282A(5).
[46] For example, *Therapeutic Guidelines: Palliative Care Version 1*, 2001 which is endorsed by wide range of medical groups including the Australasian Chapter of Palliative Medicine of The Royal Australasian College of Physicians, the Australian Pain Society, the Faculty of Pain Medicine (Australian and New Zealand College of Anaesthetists) and the Section of Consultation-Liaison Psychiatry (The Royal Australian and New Zealand College of Psychiatrists).
[47] Explanatory Notes, Criminal Code (Palliative Care) Amendment Bill 2003 (Qld), p3.

practice of the profession *in Australia*. Of course, expert evidence from palliative care specialists is also going to be relied upon heavily to establish what will constitute good medical practice.

A related issue in establishing good medical practice is the requirement that the standards, practices and procedures be "recognised". This potentially raises concerns about whether new approaches to treatment in palliative care could ever be covered by this excuse. Treatment considered to be standard today would not have been recognised as good medical practice when it was in its developmental stages. Should leading experts in palliative care progressing new approaches to the management of pain also be covered by this excuse? It is likely that the courts would be keen to avoid stifling the advancement of learning in this field and so will probably address the requirement that treatment be "recognised" quite generously. Perhaps one way to avoid this difficulty is to accept that good medical practice recognises the need to pursue new approaches to palliative care. Those pioneering in this way would be obliged to ensure, of course, that any new approach to treatment is recognised as appropriate by the medical profession.

Another comment is that s282A entrusts the medical profession to determine the appropriate standard of conduct in this context, rather than the courts. This can be contrasted with other developments in the field of health law such as negligence where the cases have been clear that the standard of care owed by doctors is determined by the courts, rather than the medical profession itself.[48] The profession's standards are very persuasive as evidence of what will be negligent or not, but the final decision is one for the courts.[49] Section s282A departs from this trend as the medical profession is given more autonomy to determine whether their behaviour is lawful or not.

A final related issue is to note that "good medical practice" sets quite a high standard in the context of criminal law. The more common standard required in this setting is that of criminal negligence which requires "such disregard for the life and safety of others as to amount to a crime against the state and conduct deserving punishment."[50] The section does require that the "provision of the palliative care is reasonable"[51] and this wording on its own may have imported that standard of criminal negligence.[52] However, this is excluded by the section as it requires not only that the treatment be reasonable, but it also provides a reference point for judging the reasonableness of that treatment by requiring that it be appropriate in the context of good medical practice. By defining what treatment will be considered to be reasonable, criminal negligence as the relevant standard is excluded.

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[48] *Rogers v Whitaker* (1992) 175 CLR 479.
[49] Although note the recent *Civil Liability Act 2003* (Qld), s22 which enhances the medical profession's role in determining the standard of care owed in negligence cases.
[50] *R v Bateman* (1925) 19 Cr App R 8 at 11-12 and *R v Scarth* [1945] St R Qd 38.
[51] *Criminal Code 1899* (Qld), s282A(1)(b).
[52] For example, s289 of the *Criminal Code 1899* (Qld) imposes a duty to act reasonably when in charge of a dangerous thing and that section has been held to import notions of criminal negligence: *R v Scarth* [1945] St R Qd 38.

This view is consistent with the Bill's second reading speech. Mr Wellington seems to expect a high level of competence on the part of those administering palliative care even referring to "best" rather than just "good" standards of medical care.[53] More importantly, he continued:

> "I also hope and expect that the reference in the bill to 'recognised medical standards, practices and procedures', may give doctors a signal that they must keep themselves up-to-date with these developments, and should warn doctors who are not up-to-date to keep right away from the administration of pain-relieving drugs in dangerous doses."[54]

Accordingly, the standard required by s282A will be ascertained as a question of fact based on medical opinion as to what constitutes good medical practice. This indicates quite an onerous standard for health care professionals who are required to stay abreast of medical advances in the palliative care field. It is for this reason that the claim made earlier that the additional requirement of s282A that treatment be administered with "reasonable care and skill" seems to be unnecessary. That phrase refers to the relatively low standard of care required under criminal negligence,[55] so treatment that satisfies the more onerous requirement of good medical practice will also be regarded as having been administered with reasonable care and skill.

However, in spite of this quite rigorous standard, it will still be difficult for the Crown to exclude this element of the excuse as it would be necessary to prove beyond reasonable doubt that that treatment was unreasonable in the context of good medical practice. This task may be made even more difficult if the courts are reluctant to apply a demanding standard, given the very serious implications that flow from criminal sanctions. It may be that the courts will take a strict approach to the need to prove that the treatment given was unreasonable. In this regard, the court may be assisted by the requirement to consider "[the patient's] state at the time and *all the circumstances of the case*" (emphasis added)[56] in determining whether the palliative care is reasonable. These words may perhaps give the court more scope to interpret "good medical practice" in a manner that is more favourable to the health care professional.[57]

Nevertheless, this requirement remains significant because it would still be much easier for the Crown to exclude this element of the excuse than to exclude intent.

Terminal Illness

[53] Hansard, Queensland Parliament, 12 March 2003, p494.
[54] Hansard, Queensland Parliament, 12 March 2003, p495.
[55] *R v Bateman* (1925) 19 Cr App R 8 at 11-12 and *R v Scarth* [1945] St R Qd 38.
[56] *Criminal Code 1899* (Qld), s282A(1)(b).
[57] For example, if care were provided in a remote area with more limited access to palliative care expertise, the court may be persuaded that "in the circumstances" of the case, the care was reasonable in the context of good medical practice, despite the fact that such care may not be so regarded if provided by a specialist palliative care team.

Section 282A does not expressly require that the patient receiving the palliative care be suffering from a terminal illness, nor is there a requirement that the patient be in the terminal phase of such an illness. This can be contrasted with the South Australian provision where both of these conditions must be met before a health care professional is protected.[58] The question remains, however, whether s282A will apply if palliative care is provided to a person who is not suffering from a terminal illness. Certainly, there is nothing in the section that would strictly limit its application in this way. In fact, the plain meaning of the provision suggests that it would not be so limited. The definition of palliative care already discussed refers to maintaining or improving the comfort of someone who is subject to pain and suffering, and clearly, these are sensations that can be experienced without a terminal illness.

Extrinsic evidence is divided on the point. The Explanatory Notes indicate that the section will only be relevant in the context of terminal illness. The Notes describe the objectives of the legislation in the following terms:

> "The object of this Bill is to clarify the obligations of doctors **treating terminally-ill patients** and to ensure that doctors … who administer palliative care to such patients … are not held under threat of prosecution …" (emphasis added).[59]

On the other hand, in his second reading speech, Mr Wellington acknowledged that the section "does not expressly limit its application to the provision of care to a terminally-ill patient".[60] The reason given was the difficulty in defining terminal illness for the purposes of the section. Although this sheds some light on the motivations behind the legislation, resolving this disagreement in the extrinsic material is unnecessary. The plain meaning of s282A is clear in that it is not limited to palliative care provided to terminally ill patients, so it not permissible to refer to the (equivocal) extrinsic evidence for further clarification.[61]

However, although s282A is not expressly limited to terminally ill patients, in practice, it is likely to apply only in such cases. Given the requirement that the

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[58] *Consent to Medical Treatment and Palliative Care Act 1995* (SA), s17(1). Whether there is a requirement for a patient to be terminally ill before the common law doctrine of double effect can apply has not expressly been considered by the courts. However, if the key to the operation of the doctrine is the intention of the medical practitioner, there does not seem to be any reason in principle why the doctrine would be limited to patients who are terminally ill. There is some support for this interpretation in L Skene, *Law and Medical Practice: Rights, Duties, Claims and Defences*, Butterworths, 1998, p221.

[59] Explanatory Notes, Criminal Code (Palliative Care) Amendment Bill 2003 (Qld), p1.

[60] Hansard, Queensland Parliament, 12 March 2003, p494. To this extent, the bill differed from the previous one introduced by Mr Wellington, the *Care of the Terminally-Ill Patients Bill 2002* (Qld), which expressly limited the protection to a person "in the terminal phase of a terminal illness": cl 2. This bill was withdrawn upon the Criminal Code (Palliative Care) Amendment Bill 2003 (Qld) being introduced: Hansard, Queensland Parliament, 12 March, 2003, p492.

[61] Pursuant to s14B of the *Acts Interpretation Act 1954* (Qld), recourse to extrinsic material is permitted if the plain meaning of the provision is ambiguous.

palliative care provided be reasonable in the context of good medical practice, it is very likely that s282A would be restricted to treatment given to patients with a terminal illness. It would be very difficult to argue that high doses of palliative drugs, such that they may cause a patient's death, would be considered appropriate as part of good medical practice outside of terminal cases.

Consent

To obtain the legislative protection in South Australia, the treatment must be given "with the consent of the patient or the patient's representative".[62] By contrast, consent to medical treatment is not mentioned in s282A, which raises the question of whether the patient must consent to the treatment for the health care professional to fall within the section's protection. Generally, the law requires that consent be obtained from a patient when providing medical treatment,[63] or from someone on his or her behalf if a patient lacks the necessary capacity.[64] Further, this consent must be valid, requiring that the patient be "informed in broad terms of the procedure intended"[65] before agreeing to that treatment. In the case of palliative care where there is a suggestion that treatment may result in the patient's death, the health care professional may be required to inform the patient of this risk for the consent to be valid.[66] Failure to obtain this consent may mean that the provider of treatment has committed an assault, and will be liable both criminally[67] and civilly.[68]

At first glance, it appears that provided the requirements of s282A are met, consent is unnecessary. However, closer examination reveals that it is likely that consent will continue to be relevant, albeit indirectly, under the new provision. As already discussed, s282A requires that the palliative care be administered reasonably as judged in the context of good medical practice. Given that the provision of palliative care without consent is likely to be unlawful, it would be difficult to contend that the care constituted good medical

[62] Consent to Medical Treatment and Palliative Care Act 1995 (SA), s17(1)(a).
[63] Note, however, that in some cases such as a medical emergency, a person may have a lawful justification for treating a patient without consent: *In Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1 at 76; *Murray v Curry* (1933) 3 DLR 260.
[64] Guardianship and Administration Act 2000 (Qld), s79.
[65] *Ellis v Wallsend District Hospital* (1989) Aust Torts Reporter 80-259 at 68,770.
[66] Although there are no cases directly on point in the context of the provision of palliative care, there is some authority that failure to advise of the possible risks of treatment may mean that the patient's consent to treatment was not valid, having being based on inadequate information: *D v S* (1981) 93 LSJS 405. Compare *Hart v Herron* (1984) Australian Torts Reporter [80-201] per Fisher J at pp 67,822 – 67,823.
[67] Assault is an offence under the *Criminal Code 1899* (Qld), s245.
[68] Civil liability arises as a result of a trespass to the person and an action in assault or battery may be brought against the health care professional: *Department of Health and Community Services (NT) v JWB (Marion's case)* (1992) 175 CLR 218 at 232. In Queensland, the appropriate tort is assault because, as defined by s245 of the *Criminal Code 1899* (Qld), it includes the tort of what was battery at common law: *White v Connolly* [1927] St R Qd 75.

practice, and therefore the health care professional may be denied the protection of the excuse.[69]

It seems that Parliament assumed that consent would always be necessary as a compulsory part of good medical practice. According to Mr Wellington, the requirement that palliative care be "reasonable" could only be satisfied if consent were obtained.[70] Further, when introducing his bill, Mr Wellington noted that it did not expressly require a patient's consent, but he observed that this "does not mean that a doctor can administer palliative care without the appropriate consent."[71]

Given the role that consent plays in s282A, the excuse is materially different from the common law doctrine of double effect. That doctrine is based on the intent of the health care professional so the issue of consent is irrelevant. The Queensland provision therefore reflects more closely its South Australian equivalent, which specifically requires that consent of the patient or representative be obtained.[72]

The result is that there will be some circumstances in which a person who would have been protected by the doctrine of double effect will not fall within the s282A excuse.[73] If health care professionals providing palliative care always observe the requirement to obtain consent before treatment is given, then the s282A excuse may be available to them. If there are circumstances in practice where consent is not obtained, then the health care professional is at risk as discussed above. This raises the question of whether s282A strikes the appropriate balance. The outcome of the provision seems rather disproportionate in that a failure to obtain consent could bring the very grave consequence of being judged guilty of the crime of murder. While it is accepted that some criminal (and indeed civil) responsibility should flow from administering treatment without consent, whether it should be so substantial is questionable. The common law doctrine of double effect takes a more balanced approach. Although providing protection from liability for unlawful killing, the doctrine still leaves health care professionals who fail to obtain consent liable for prosecution for criminal assault.

<u>"In Writing"</u>

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[69] In the second reading speech introducing the Bill into Parliament, Mr Wellington makes the assumption that provision of palliative care is reasonable only if the appropriate consent is obtained: Hansard, Queensland Parliament, 12 March 2003, p493. Of course, consent alone is insufficient justification to afford a defence to murder or manslaughter. See s284 of the *Criminal Code 1899* (Qld) which provides that a person cannot consent to their own death.

[70] In supporting this proposition, Mr Wellington commented that "hospital administrators must be aware of the provisions of the *Guardianship and Administration Act 2000* with respect to consent to treatment": Hansard, Queensland Parliament, 12 March 2003, p494.

[71] Hansard, Queensland Parliament, 12 March 2003, p494.

[72] *Consent to Medical Treatment and Palliative Care Act 1995* (SA), s17(1)(a). Interestingly, the original version of Mr Wellington's Bill was modelled on the South Australian provision and expressly required consent to be obtained.

[73] As the *Criminal Code (Palliative Care) Amendment Act 2003* (Qld) statutorily enshrines the doctrine of double effect, the doctrine ceases to operate in Queensland.

One of the elements of s282A is that the person providing the care is either a doctor, "or if the person is not a doctor, the palliative care is ordered by a doctor who confirms the order in writing".[74] The equivalent South Australian provision may be relied upon by a medical practitioner "or a person participating in the treatment or care … under the medical practitioner's supervision."[75] There is no requirement in the latter case for the supervising medical practitioner to put their instructions in writing.

As was noted earlier, from a legal perspective, the requirement of writing is merely procedural: if the care is not provided by a doctor, either the order is in writing or it is not. However, in practice, this requirement is likely to have significant implications, particularly for nurses who administer this sort of treatment. Two examples illustrate some of the difficulties that this procedural requirement may present.

The first relates to some of the care provided by nursing staff to residents of aged care facilities who have lost or are losing some capacity to care for themselves. The definition of palliative care in s282A is quite inclusive and would cover some of the routine assistance provided by nurses to make these patients more comfortable, such as regular rolling to avoid pressure sores. Currently, it is not standard practice for all of the care that falls within this definition to be ordered by doctors in writing. Of course, it should be made clear that generally only care which may possibly cause or hasten death would need the protection of s282A, so it is not necessary for trivial care to be documented in this way. Nevertheless, care which is currently provided primarily by nurses may need greater involvement from doctors to comply with the excuse.

A second example raises difficulties where a doctor is not available to confirm an order in writing, perhaps because it is late at night or because the patient is in a rural location. Instead, drugs are administered by a nurse based on an oral authorisation over the telephone, and the allegation is then made that those drugs hastened the patient's death. It is likely that the wording of s282A would permit a doctor to put the order in writing after the care was given, as he or she may already do under other legislation.[76] However, there is the possibility that a doctor, when confronted with an adverse outcome such as the death of the patient, may wish to distance him or herself from the event and refuse to confirm the order in writing.[77] This would leave members of the nursing team exposed to potential criminal liability for merely failing to comply with a procedural element of the excuse. It is likely that the courts would go to some lengths to avoid such an unjust outcome. However, it is suggested that they would struggle to achieve this given the clear wording of s282A. In any event, nurses should be able to administer drugs that they are authorised to

[74] *Criminal Code 1899* (Qld), s282A(1)(c).
[75] Consent to Medical Treatment and Palliative Care Act 1995 (SA), s17(1).
[76] Health (Drugs and Poisons) Regulation 1996 (Qld), s97(1).
[77] Of course, a doctor who failed to subsequently confirm an order in writing in contravention of s97(1) of the *Health (Drugs and Poisons) Regulation* 1996 (Qld) may be fined 40 penalty units (which is currently $3 000: *Penalties and Sentences Act 1992* (Qld), s5(1)).

give without having to rely on the courts to distort the law to protect them from liability.

Criminal and Civil Liability

Section 282A only protects doctors from being attributed with criminal responsibility. This can be contrasted with the South Australian legislation, which specifically excludes both criminal and civil liability.[78] In Queensland, therefore, there is at least a possibility that a health care professional who was unsuccessfully prosecuted for unlawful killing because the Crown could not prove its case beyond reasonable doubt, could then be the subject of a civil action. The surviving relatives would be able to bring such an action, provided that the deceased patient would have been able to successfully sue for the act that caused his or her death.[79] In practice, however, this civil action is not likely to be brought. The damages in these actions are assessed by reference to the loss of the relatives, rather than the patient, and relatives in these situations have generally suffered very little compensable loss, if any. This is particularly so if the medical treatment that caused the death merely hastened it by minutes, hours or days.

Also of significance is that the protection provided by s282A refers to criminal responsibility generally and so applies to all criminal offences, rather than just to those based on unlawful killing. This is wider than the doctrine of double of effect, which only provides an excuse for a patient's death.

Likely Outcomes of section 282A

Section 282A has three major implications for the law in Queensland. The first is that it brings greater legal certainty for those administering and receiving palliative care. In Queensland, it is now clear that a health care professional who, in accordance with good medical practice, administers treatment with the appropriate level of documentation and with the intention of relieving pain will not be criminally responsible even if this treatment incidentally shortens life. The excuse effectively eliminates concerns that health care professionals may have had about being prosecuted for ensuring that their patients are made comfortable in accordance with recognised medical standards.

The reform also provides greater certainty for health care professionals because, in addition to clarifying the law, it also allows these professionals to have more control over its scope. The reference to "good medical practice" means that the standard required is set by the medical profession. Instead of having to look beyond their own field to identify the required legal standard, it is only necessary to be aware of what is considered by the profession to be good practice. Of course, the value of the greater legal certainty afforded to health care professionals by this excuse is only half of the story. Section 282A also brings important benefits to those patients receiving palliative care and their families. By clarifying the legal obligations of health care professionals,

[78] Consent to Medical Treatment and Palliative Care Act 1995 (SA), s17.
[79] Supreme Court Act 1995 (Qld), s17.

they have greater freedom to treat so that the pain of patients can be managed more effectively.

The second implication of the provision is that although those administering and receiving palliative are likely to welcome this increased legal certainty, it comes at a price. The first part of the price is the requirement that the palliative care either be provided by a doctor or that the order for the care is confirmed in writing by a doctor. This asks more of health care professionals, and particularly nurses, in terms of how this care is provided and then documented. The second and more substantive part of the price is that s282A demands greater competence of those administering palliative care. The provision demands that the treatment provided be reasonable in the context of good medical practice before protection is granted. Of particular importance is that the standard required by the provision is quite demanding, given the possible criminal liability that could result. These requirements of greater competence and documentation are in addition to having the appropriate intent and so go beyond the common law doctrine of double effect. That doctrine is less stringent because although good medical practice and documentation will be very relevant in determining a doctor's intention, they are not formally required for the doctrine to apply.

This additional requirement that palliative care be reasonable in the context of good medical practice is particularly significant. In a case where the Crown may struggle to prove that the health care professional did not have the appropriate intent, it can still exclude the excuse by proving that the palliative care provided was unreasonable in the context of good medical practice. This is significant because this alternative route to conviction is much easier to establish than a health care professional's subjective intent, because what is good medical practice is a standard that can be objectively determined. This means that s282A does more than its stated objective of enshrining the doctrine of double effect. It establishes a test that in practice is most likely to be based on good medical practice, rather than intent. It is also noted that good medical practice, a seemingly simple obligation, also creates quite a significant hurdle for health care professionals by importing a whole host of other considerations not mentioned by s282A, such as the need for consent, or the likely requirement that the patient be suffering from a terminal illness. As mentioned, the practical impact of this could be significant. A health care professional who previously could have relied on the common law doctrine of double effect, now abolished by s282A, may not obtain the protection of the excuse with its more onerous requirements.

The third and final implication of s282A is that euthanasia remains illegal in Queensland, and this is made specifically clear by the section itself. The excuse is limited and does not permit an act or omission to be done with the intent to kill the patient, nor does it justify aiding another person to kill himself or herself. Acts of this kind would also be inconsistent with other requirements of the provision such as the obligation to provide treatment with the appropriate intent, or for such treatment to be reasonable in the context of good medical practice.

Section 282A is a relatively short section purporting to do little more than statutorily enshrine an existing common law doctrine to remove doubt and promote certainty. However, the provision goes well beyond confirming the existing law and creates an excuse that is significantly more stringent than the doctrine of double effect. Overall, the reform is a positive one in that it provides greater legal certainty for health care professionals and patients. Concerns about being prosecuted because the law was not clear have been met. However, this certainty comes at a price because s282A also requires greater competence and documentation of those administering palliative care. Health care professionals making dying patients as comfortable as possible must now ensure that the care provided to achieve this is appropriately documented and reasonable in the context of good medical practice.